

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

12475

CERTIFICATE OF DEATH

12451

Reg. Dist. No.

TO HOSPITAL (may be retained by the hospital or attending physician).
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY Cecil		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) STATE Maryland	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Port Deposit, Rural		c. LENGTH OF STAY IN 1b Life	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Virginia Middle Hawley Last Abrahams		4. DATE OF DEATH Month Nov. 18 Day Year 1959	
S. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Oct. 19, 1873
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Home Maker		10b. KIND OF BUSINESS OR INDUSTRY Own Home	
11. BIRTHPLACE (State or foreign country) Md.		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Cornelius S. Abrahams		14. MOTHER'S MAIDEN NAME Clara D. Vanneman	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. INFORMANT Cornelia S. Abrahams, Port Deposit, Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b) and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 331X Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause lost. DUE TO (b) DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH 4 months Cerebral Hemorrhage - Paralysis Left Side - Cataract Sclerotic - Cerebral Sclerosis 10 yrs	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) Myocarditis		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>June 20, 1959</u> to <u>October 17, 1959</u> that I last saw the deceased alive on <u>Aug 17, 1959</u> , and that death occurred at <u>6:30</u> M, from the causes and on the date stated above.		ADDRESS (Street, city or town, state) Port Deposit, Md.	
ACTUAL SIGNATURE <i>Clarence I. Benson, M.D.</i>		DATE SIGNED 11/19/59	
PHYSICIAN'S NAME (Type) Clarence I. Benson, M.D.			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 11-21- 1959	
22c. NAME OF CEMETERY OR CREMATORIAL Hopewell Cemetery		22d. LOCATION (City, town, or county) (State) Port Deposit, Md. Rural	
23. FUNERAL DIRECTOR'S SIGNATURE <i>Leila Patterson, Jr.</i>		24a. REC'D BY REGISTRAR DATE NOV 23 '59	
ADDRESS Perryville, Md.		24b. REGISTRAR'S SIGNATURE <i>Arthur S. Trahan</i>	

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

12475

CERTIFICATE OF DEATH

12453

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY CECIL		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE MARYLAND	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) NORTH EAST RI		b. COUNTY CECIL	
c. LENGTH OF STAY IN 1b 41		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) X NORTH EAST	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		d. STREET ADDRESS 1	
e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print)	First CRESS	Middle A.	Last BEAMER
4. DATE OF DEATH	Month 11	Day 19	Year 1959
5. SEX MALE	6. COLOR OR RACE WHITE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH September 22 1879
9. AGE (In years lost birthday) 79 yrs.	10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) FARMER	11. KIND OF BUSINESS OR INDUSTRY FARM OWNER	12. BIRTHPLACE (State or foreign country) PENNA
13. FATHER'S NAME PETER M BEAMER	14. MOTHER'S MAIDEN NAME JANE WARREN	15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No	
16. SOCIAL SECURITY NO. 220-34-7071		17. INFORMANT Mrs. Olive Black, Elton RD 5 Md	Address
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 1533 Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause first (b) (c)		INTERVAL BETWEEN ONSET AND DEATH Ten months 18 months	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While Not while of work <input type="checkbox"/> of work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>Sept 16</u> , 1959, to <u>Sept 19</u> , 1959, that I last saw the deceased alive on <u>Sept 16</u> , 1959, and that death occurred at <u>Sept 19</u> , 1959, M, from the causes and on the date stated above. ACTUAL SIGNATURE <u>Dr. M. J. Holcomb</u> M.D.		ADDRESS (Street, city or town, state) DATE SIGNED	
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		22b. DATE THEREOF 11-22-1959	22c. NAME OF CEMETERY OR CREMATORIAL BAY VIEW METHODIST
23. FUNERAL DIRECTOR'S SIGNATURE Joseph R. Grant North East. Md		ADDRESS	22d. LOCATION (City, town, or county) BAY VIEW, CECIL CO., MD. (State)
24a. REC'D BY REGISTRAR DATE NOV 24 '59		24b. REGISTRAR'S SIGNATURE Arthur S. Thorne	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
Item 9 Form G251 11/12/23 TWA
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

12452

Reg. Dist. No.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with Farm PM3. Page 5 may be retained for your files.
 TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File Pages 1 and 2 with the registrar prior to burial, cremation, or removal.

1. PLACE OF DEATH a. COUNTY Cecil		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE Maryland		b. COUNTY Cecil	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Elkton		c. LENGTH OF STAY IN 1b 15 yrs		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Elkton		d. STREET ADDRESS 237 West Main	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Union Hospital				e. DATE OF DEATH 11 3 1959		f. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) Harriet R. Barnard		First	Middle	Last	Month	Day	Year
5. SEX Female		6. COLOR OR RACE white	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH July 4, 1877	9. AGE (In years last birthday) 82 83 yrs.	10. IF UNDER 1 YEAR Months —	11. IF UNDER 24 HRS. Hours —
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY —		11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME John P. Winchester		14. MOTHER'S MAIDEN NAME Elizabeth Martin		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) —		16. SOCIAL SECURITY NO. none	
17. INFORMANT Mrs. Edward T. Williams		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 900.0 DUE TO Fracture of the base of skull neck of the left femur		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>		INTERVAL BETWEEN ONSET AND DEATH	
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Fell down stairway		20c. TIME OF INJURY Month, Day, Year Hour a. m. 2:30 p. m. 11-3 1959		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Home		20f. (City or town) Elkton		(County) Cecil		(State) Maryland	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and find that death resulted from Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/>							
ACTUAL SIGNATURE <i>R.C. Dodson</i>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>		DATE SIGNED 11-3-1959	
EXAMINER'S NAME (Type) R.C. Dodson		DEPUTY MEDICAL EXAMINER <input type="checkbox"/>					
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 11-6-1959		22c. NAME OF CEMETERY OR CREMATORIAL Principio Methodist		22d. LOCATION (City, town, or county) Principio, Cecil Co., Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE <i>Joseph R. Grant</i>		ADDRESS North East, Maryland		24a. REC'D BY REGISTRAR —		24b. REGISTRAR'S SIGNATURE <i>Charles E. Tamm</i>	
VS. AT SME(S) SM 9/55		DATE NOV 6 '59					

WEDNESDAY EVENING CEREMONY OF DEATH

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4
 may be retained by the hospital or attending physician.

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MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

12464

CERTIFICATE OF DEATH

12454

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <i>Cecil</i>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <i>MARYLAND</i> b. COUNTY <i>Maryland</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Charlestown Elton</i>		c. LENGTH OF STAY IN 1b <i>78 days</i>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>Union Hospital</i>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Charlestown</i>	
e. STREET ADDRESS —		d. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <i>Claude E. Beldin</i>		First	Middle
4. DATE OF DEATH <i>Nov 25 1959</i>		Month	Day Year
5. SEX <i>M</i>	6. COLOR OR RACE <i>W</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>Feb. 29, 1888</i>
9. AGE (In years lost birthday) <i>71 yrs.</i>		10. IF UNDER 1 YEAR Months <i>0</i> Dots <i>0</i> Hours <i>0</i> Min. <i>0</i>	11. IF UNDER 24 HRS. Months <i>0</i> Dots <i>0</i> Hours <i>0</i> Min. <i>0</i>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Construction Supervisor</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>Construction</i>	
11. BIRTHPLACE (State or foreign country) <i>Penna.</i>		12. CITIZEN OF WHAT COUNTRY? <i>U.S.</i>	
13. FATHER'S NAME <i>Beldin</i>		14. MOTHER'S MAIDEN NAME <i>Josephine Walker</i>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <i>Unk</i>		16. SOCIAL SECURITY NO. <i>217-03-3353</i>	
17. INFORMANT <i>Elvira A. Beldin wife</i>		Address <i>as above</i>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Heart failure</i>			
350X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause lost. (b) <i>Parkinson's Disease, severe</i>			
Many years			
DUE TO (c) <i>Arteriosclerosis, generalized, severe</i>			
Many years			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <i>None</i>			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <i>N/A</i>	
20c. TIME OF INJURY Month, Doy, Year Hour a. m. <i>19</i>		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) <i>Elton</i> (County) <i>Md.</i> (State)	
21. I certify that I attended the deceased from <i>Nov. 18, 1959</i> to <i>Nov 25, 1959</i> , that I last saw the deceased alive on <i>Nov. 25, 1959</i> , and that death occurred at <i>4125th St. M.</i> from the causes and on the date stated above.			
ACTUAL SIGNATURE <i>Tillman D. Johnson</i>		ADDRESS (Street, city or town, state) <i>123 Sengely Ave., Elton, Md.</i>	
PHYSICIAN'S NAME (Type) <i>Tillman D. Johnson</i>		DATE SIGNED <i>11-28-1959</i>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>BURIAL</i>		22b. DATE THEREOF <i>11-28-1959</i>	
22c. NAME OF CEMETERY OR CREMATORIY <i>CHARLESTOWN METHODIST</i>		22d. LOCATION (City, town, or county) (State) <i>CHARLESTOWN, CECIL, Md.</i>	
23. FUNERAL DIRECTOR'S SIGNATURE <i>Joseph R. Frank North East Md</i>		ADDRESS	
24a. REC'D BY REGISTRAR		24b. REGISTRAR'S SIGNATURE <i>Arthur S. Krause</i>	
DATE <i>NOV 30 '59</i>			

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

12477

CERTIFICATE OF DEATH

12455

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Cecil		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Md.		b. COUNTY Cecil	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cecilton		c. LENGTH OF STAY IN 1b RURAL and give nearest town)		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cecilton		d. STREET ADDRESS	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION						e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print)	First BENJAMIN	Middle FRANK	Last BIGGS	4. DATE OF DEATH November	Month 22	Day 1959	Year
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH September 28, 1875	9. AGE (In years lost birthday) 84 yrs.	IF UNDER 1 YEAR Months 0	IF UNDER 24 HRS. Days 0	Hours 0
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Farmer Retired		10b. KIND OF BUSINESS OR INDUSTRY Farm		11. BIRTHPLACE (State or foreign country) Md.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Frank Biggs		14. MOTHER'S MAIDEN NAME Susan Hessey					
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT Raymond Biggs,		Address Cecilton, Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Carcinoma of Stomach with extension to liver</u>						INTERVAL BETWEEN ONSET AND DEATH 0 mos.	
151X Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last. (b)		DUE TO					
{ DUE TO (c)							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Malnutrition						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Hour o. m. p. m.	Month 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) Cecilton	(County) Md.	(State) Md.	
21. I certify that I attended the deceased from <u>June</u> , 1959, to <u>Nov 22</u> , 1959, that I last saw the deceased alive on <u>Nov 22</u> , 1959, and that death occurred at <u>11:30p</u> M, from the causes and on the date stated above.				ADDRESS (Street, city or town, state) Cecilton, Md.		DATE SIGNED 22 NOV 59	
ACTUAL SIGNATURE Wallace Obenshain	MD.						
PHYSICIAN'S NAME (Type) Wallace Obenshain, M.D.		Cecilton, Md.					
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF Nov. 25, 1959	22c. NAME OF CEMETERY OR CREMATORIAL Cecilton Cemetery	22d. LOCATION (City, town, or county) Cecilton, Cecil Co.	22e. (State) Md.			
23. FUNERAL DIRECTOR'S SIGNATURE Edward Fellows.		ADDRESS Mellington Md.	24a. REC'D BY REGISTRAR NOV 30 '59	24b. REGISTRAR'S SIGNATURE Arthur S. Evans			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death: Page 4
 may be retained by the hospital or attending physician.
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

12456

Reg. Dist. No.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "Pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with farm PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

1. PLACE OF DEATH a. COUNTY Cecil		b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Elkton		c. LENGTH OF STAY IN 1b 3 hours		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE Del.		b. COUNTY	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Union Hospital		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Wyoming, Del.		d. STREET ADDRESS Wyoming Rd		e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) Isaac		First	Middle	Last	4. DATE OF DEATH Month 11 Day 14 Year 1959				
5. SEX M		6. COLOR OR RACE W	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH 11-10-38	9. AGE (in years last birthday) 21 yrs.	10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laborer		11. BIRTHPLACE (State or foreign country) Magnolia, Del	
12. CITIZEN OF WHAT COUNTRY? U.S.A.									
13. FATHER'S NAME Walter F. Bishop		14. MOTHER'S MAIDEN NAME Rachel Shahan							
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) yes		16. SOCIAL SECURITY NO. Navy		17. INFORMANT Mrs. Rachel Bishop. Wyoming, Del. R.D.L		Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)		Crushed both sides of chest				INTERVAL BETWEEN ONSET AND DEATH			
823X Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b)		DUE TO							
DUE TO (c)									
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Car hit electric light pole							
20c. TIME OF INJURY 2:10 p.m.		Month, Day, Year 11 14 59	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Apartment	20f. (City or town) Cecilton, Cecil,	(County) Md.	(State)		
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input type="checkbox"/> , and find that death resulted from: Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .									
ACTUAL SIGNATURE R.C. Dodson		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>		DATE SIGNED 11-14-59			
EXAMINER'S NAME (Type) R.C. Dodson		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>							
22a. BURIAL, CREMATION, REMOVAL (Specify) Buried		22b. DATE THEREOF 17/10/59		22c. NAME OF CEMETERY OR CREMATORIAL Lake Side		22d. LOCATION (City, town, or county) Dover Del			
23. FUNERAL DIRECTOR'S SIGNATURE William E. Tolbert		ADDRESS 1401 W. 10th Street		24a. REC'D BY REGISTRAR NOV. 7 '59		24b. REGISTRAR'S SIGNATURE C. Tolbert & Son			

18 - BOSTON - HANOVER - NEW YORK
AERONAUTICAL CHAMBER OF COMMERCE

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Reg. Dist. No.

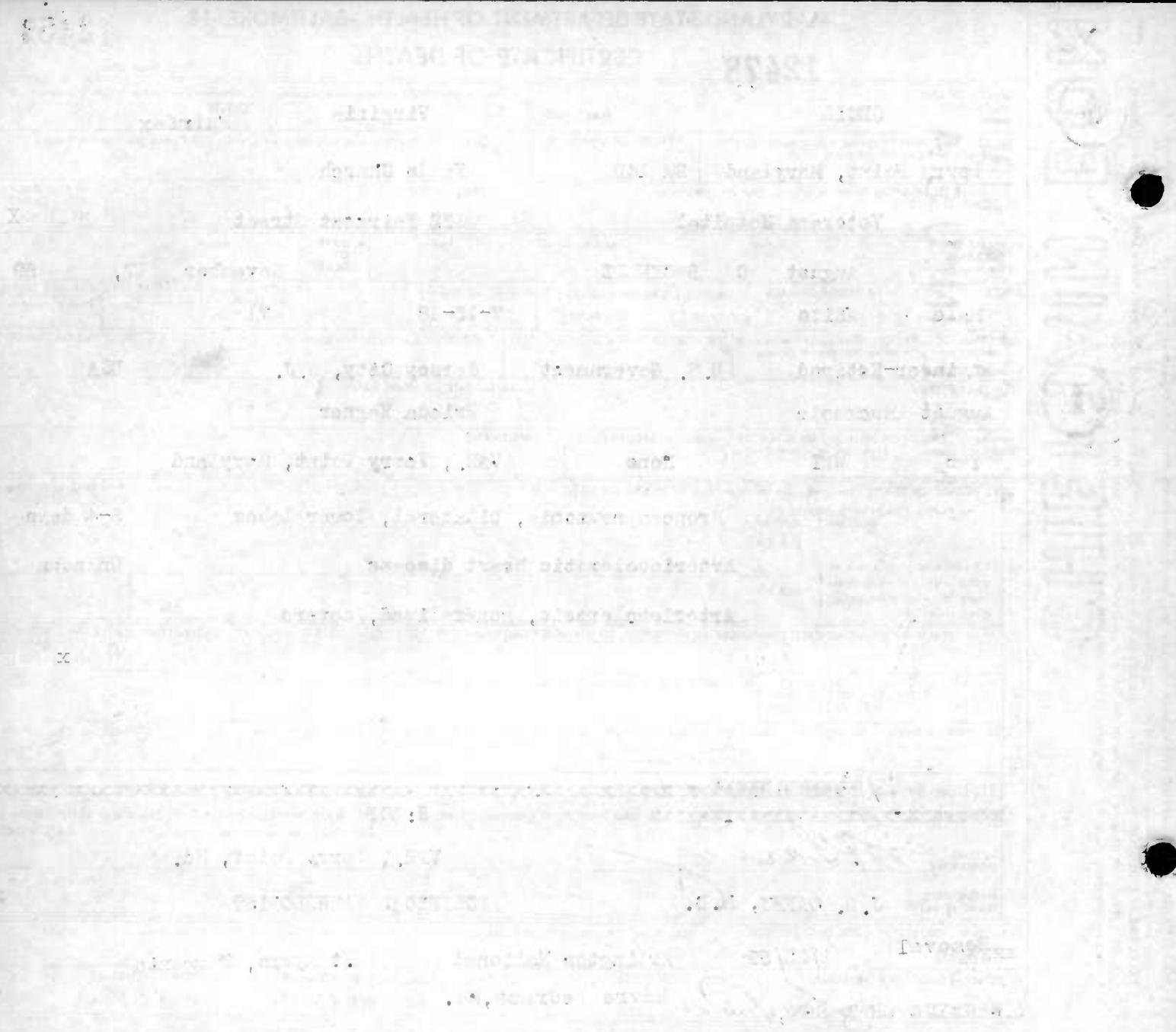
12478

CERTIFICATE OF DEATH

HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial/transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

<p>1. PLACE OF DEATH a. COUNTY CECIL MARYLAND</p> <p>b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Perry Point, Maryland</p> <p>c. LENGTH OF STAY IN 1b 2M 14D</p> <p>d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Veterans Hospital</p>				<p>2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Virginia b. COUNTY Fairfax</p> <p>c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Falls Church</p> <p>d. STREET ADDRESS 132 Fairmont Street</p>			
<p>3. NAME OF DECEASED (Type or print) August C BUCKHOLZ</p>				<p>4. DATE OF DEATH Month November Day 17, Year 1959</p>			
<p>5. SEX Male</p>		<p>6. COLOR OR RACE White</p>		<p>7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/></p> <p>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/></p>		<p>8. DATE OF BIRTH 7-15-88</p>	
<p>10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Engineer-Retired</p>		<p>10b. KIND OF BUSINESS OR INDUSTRY U. S. Government</p>		<p>11. BIRTHPLACE (State or foreign country) Jersey City, N.J.</p>		<p>12. CITIZEN OF WHAT COUNTRY? USA</p>	
<p>13. FATHER'S NAME August Buckholz</p>				<p>14. MOTHER'S MAIDEN NAME Frieda Wagner</p>			
<p>15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Yes</p>		<p>16. SOCIAL SECURITY NO. (If yes, give war or dates of service) WVI</p>		<p>INFORMANT VAH., Perry Point, Maryland</p>		<p>Address</p>	
<p>18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]</p> <p>PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Bronchopneumonia, bilateral, lower lobes INTERVAL BETWEEN ONSET AND DEATH 3-4 days</p> <p>420.0 DUE TO</p> <p>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Arteriosclerotic heart disease Unknown</p> <p>DUE TO</p> <p>(c) Arteriosclerosis, generalized, severe</p> <p>PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(c)</p> <p>20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)</p> <p>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)</p> <p>20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 20d. INJURY OCCURRED p. m. VA While 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State) at work <input type="checkbox"/> at work <input type="checkbox"/></p> <p>21. I certify that I DeGrace and that death occurred at 8:30 P.M. from the causes and on the date stated above.</p> <p>ADDRESS (Street, city or town, state) VAH., Perry Point, Md. DATE SIGNED</p> <p>ACTUAL SIGNATURE J. L. GAREY, M.D.</p> <p>PHYSICIAN'S NAME (Type)</p> <p>22a. BURIAL, CREMATION, (If removed) 22b. DATE THEREOF 22c. NAME OF CEMETERY OR CREMATORIAL 22d. LOCATION (City, town, or county) (State) Burial 11/23/59 Arlington National Ft Myers, Virginia</p> <p>23. FUNERAL DIRECTOR'S SIGNATURE ADDRESS 24a. REC'D BY REGISTRAR 24b. REGISTRAR'S SIGNATURE R. DeGrace, M.D. Havre DeGrace, Md. NOV 27 59 C. DeGrace, M.D.</p>							



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death: Page 4
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MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 12458

CERTIFICATE OF DEATH

Reg. Dist. No. _____

1. PLACE OF DEATH a. COUNTY <i>Cecil</i> —		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <i>Maryland</i> b. COUNTY <i>Cecil</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Elkton</i>		c. LENGTH OF STAY IN 1b <i>60 yrs.</i>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>115 Bridge Street.</i>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Elkton - Md.</i>	
d. STREET ADDRESS <i>115 Bridge St —</i>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <i>Murray Wilkerson</i>		First <i>First</i>	Middle <i>Bunce</i>
4. DATE OF DEATH <i>Nov. 13 1959</i>		Month <i>Nov.</i>	Day <i>13</i>
5. SEX <i>Male</i>		6. COLOR OR RACE <i>White</i>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>
8. DATE OF BIRTH <i>Oct. 28 1882</i>		9. AGE (In years to birthday) yrs. <i>77</i>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Salvage</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>Hotel Co.</i>	
11. BIRTH PLACE (State or foreign country) <i>Baltimore - Md.</i>		12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>	
13. FATHER'S NAME <i>Davis Bunce</i>		14. MOTHER'S MAIDEN NAME <i>Mary Deal</i>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <i>No</i>		16. SOCIAL SECURITY NO. <i>216-07-2069</i>	
17. INFORMANT <i>Wife Bessie Draper Bunce</i>		Address <i>Elkton, Md.</i>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]		INTERVAL BETWEEN ONSET AND DEATH <i>5 mos</i>	
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>450.0</i>		DUE TO <i>Myocardial failure</i>	
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <i>General Atherosclerosis</i>		DUE TO (c) <i>Unknown</i>	
Part II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 1b.)	
20c. TIME OF INJURY Hour a. p. m. <i>19</i>		20d. INJURY OCCURRED White at work <input type="checkbox"/> Not white at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <i>Home</i>		20f. (City or town) <i>Elkton</i> (County) <i>Md.</i> (State) <i>Md.</i>	
21. I certify that I attended the deceased from <i>1959</i> to <i>Nov. 13 1959</i> , that I last saw the deceased alive on <i>November 12 1959</i> and that death occurred at <i>Elkton</i> M. from the causes and on the date stated above.			
ACTUAL SIGNATURE <i>V. H. McKnight</i>		ADDRESS (Street, city, county, state) <i>113 Bridge St - Elkton - Md.</i> DATE SIGNED <i>1959</i>	
PHYSICIAN'S NAME (Type) <i>V. H. McKnight</i>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		22b. DATE THEREOF <i>11-15-59</i>	
22c. NAME OF CEMETERY OR CREMATORIAL <i>Elkton Cemetery</i>		22d. LOCATION (City, town, or county) <i>Elkton</i> (State) <i>Md.</i>	
23. FUNERAL DIRECTOR'S SIGNATURE <i>Pippin Funeral Home</i>		ADDRESS <i>Donald M. See Elkton, Md.</i>	
24a. REC'D BY REGISTRAR <i>NOV 18 1959</i>		24b. REGISTRAR'S SIGNATURE <i>Arthur L. Kline</i>	

STATE OF HAWAII - DEPARTMENT OF HEALTH

CERTIFICATE OF DEATH

NAME

ADDRESS

CITY

STATE

ZIP

PHONE

FAX

EMAIL

SSN

MRN

ID#

DEATH DATE

TIME

AGE

SEX

RACE

ETHNICITY

RELIGION

CULTURE

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RACE

ETHNICITY

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

12459

Item 12 Filing 252 11-23-59 et

Reg. Dist. No.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

1.		PLACE OF DEATH a. COUNTY Cecil		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE Md.		b. COUNTY Cecil			
12479		12479		c. LENGTH OF STAY IN lb 2 yrs		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) North East R.D.		d. STREET ADDRESS Graybeal Nursing Home			
090		d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Graybeal Nursing Home						e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
I		3. NAME OF DECEASED (Type or print) John Chafchie		First John		Middle Chafchie		Last		4. DATE OF DEATH 11 17 1959	
I		5. SEX M		6. COLOR OR RACE W		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>		8. B. DATE OF BIRTH 1881		9. AGE (In years last birthday) 78 yrs.	
I		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laborer		10b. KIND OF BUSINESS OR INDUSTRY Farm		11. BIRTHPLACE (State or foreign country) Poland		12. CITIZEN OF WHAT COUNTRY? Poland			
I		13. FATHER'S NAME no information		14. MOTHER'S MAIDEN NAME no information							
I		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. no		17. INFORMANT Graybeal Nursing Home, Nottingham, Pa.		Address			
I		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]									
I		PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)		Chronic Myeloiditis							
I		422.2 DUE TO									
I		Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b)									
I		DUE TO (c)									
I		PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)									
I		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>									
I		20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)							
I		20c. TIME OF INJURY Hour a. m. p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)					
I		19									
I		21. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and find that death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/>									
I		ACTUAL SIGNATURE R.C. Dodson									
I		EXAMINER'S NAME (Type) R.C. Dodson									
I		22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 11-20-59		22c. NAME OF CEMETERY OR CREMATORIUM West Nottingham		22d. LOCATION (City, town, or county) Colo. Md.			
I		23. FUNERAL DIRECTOR'S SIGNATURE Vernon E. McMillan		ADDRESS Rising Sun Md.		24a. REC'D BY REGISTRAR NOV 20 '59		24b. REGISTRAR'S SIGNATURE Arthur S. Evans			
I											

WATER-SOLUBLE POLYMER COMPOSITIONS
AND POLYACRYLIC ACID EXAMINERS CERTIFICATE OF DATA

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/58

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

12460

Reg. Dist. No. 96

1. PLACE OF DEATH a. COUNTY Cecil		12480 MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland		b. COUNTY Queen Anne's		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Perry Point		c. LENGTH OF STAY IN 1b 14 yrs. 1 mo. 1 days		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Centreville		d. STREET ADDRESS 17 X-2		
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Veterans Administration Hospital				d. STREET ADDRESS		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
3. NAME OF DECEASED (Type or print)	First HENRY	Middle E.	Last CONLEY	4. DATE OF DEATH	Month November	Day 16	Year 19 59	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	B. DATE OF BIRTH 10-31-94	9. AGE (In years last birthday) 65 yrs.	IF UNDER 1 YEAR Months 0	IF UNDER 24 HRS. Days 0	Hours 0	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Farmer		10b. KIND OF BUSINESS OR INDUSTRY Self-employed		11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? USA		
13. FATHER'S NAME Samuel P. Conley		14. MOTHER'S MAIDEN NAME Augusta Walls						
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Yes	16. SOCIAL SECURITY NO. 214-10-0715	INFORMANT Hospital Records, VAH, Perry Point, Md.	Address					
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]								
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary thrombosis INTERVAL BETWEEN ONSET AND DEATH 5 hours								
DUE TO 420.0								
Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause lost. (b) Arteriosclerotic heart disease								
DUE TO (c)								
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)								
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>								
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)								
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Arteriosclerosis generalized severe								
20c. TIME OF INJURY Hour o. m. p. m. UA		Month 19	Day 15	Year 1945	20d. INJURY OCCURRED While at work <input type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from October 15, 1945 , to November 16 1959 and that death occurred at 2:30 AM , from the causes and on the date stated above.								
ADDRESS (Street, city or town, state)								
DATE SIGNED								
ACTUAL SIGNATURE	<i>J. L. Garey</i>		M.D. V.A. Hospital, Perry Point, Md. 11-16-59					
PHYSICIAN'S NAME (Type)	Clinical Pathologist							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 3-18-59	22c. NAME OF CEMETERY OR CREMATORIAL Chesterfield	22d. LOCATION (City, town, or county) Centreville Maryland					
23. FUNERAL DIRECTOR'S SIGNATURE <i>Barton Brothers</i>	ADDRESS Centreville, Maryland	24a. REC'D BY REGISTRAR DATE NOV 19 '59		24b. REGISTRAR'S SIGNATURE <i>Arthur S. Kraus</i>				

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

12461

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Cecil		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Md.	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Colora		c. LENGTH OF STAY IN 1b Life	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) Lewis		First Alexander	Middle Last Ewing
4. DATE OF DEATH	Month 11	Day 16	Year 1959
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Oct. 9, 1906
9. AGE (In years last birthday) 53 yrs.	10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Mechanic	11. BIRTHPLACE (State or foreign country) Cecil Co. Md.	12. CITIZEN OF WHAT COUNTRY? U.S.A.
13. FATHER'S NAME Edward Elie Ewing	14. MOTHER'S MAIDEN NAME Lenna May Gibson	15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No	
16. SOCIAL SECURITY NO. 218-03-1778	17. INFORMANT Mrs. Dorothy Ewing, Colora, Md.	Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]			
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 420.1 DUE TO Myocardial Infarction INTERVAL BETWEEN ONSET AND DEATH 1 hour			
Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last. (b) DUE TO Coronary Sclerosis 2 yrs.			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from _____, 1958, to _____, 1959, that I last saw the deceased alive on _____, 1959, and that death occurred at _____, 11 A.M., from the causes and on the date stated above.			
ACTUAL SIGNATURE Neil Taylor Jr.		ADDRESS (Street, city or town, state) Rising Sun, Md. DATE SIGNED 11/17/59	
PHYSICIAN'S NAME (Type) Neil Taylor Jr.		Rising Sun, Md. 11/17/59	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 11/19/1959	22c. NAME OF CEMETERY OR CREMATORIUM Brookview Cem.	22d. LOCATION (City, town, or county) Rising Sun (State) Md.
23. FUNERAL DIRECTOR'S SIGNATURE J. Earl Tyson		ADDRESS Rising Sun MD.	24a. REC'D BY REGISTRAR DATE NOV 19 '59
			24b. REGISTRAR'S SIGNATURE Arthur S. Kline

Digitized by srujanika@gmail.com

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

12462

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY		12467		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)							
Cecil		MARYLAND		a. STATE Maryland		b. COUNTY Cecil					
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)		c. LENGTH OF STAY IN 1b		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)		d. STREET ADDRESS					
Elkton		D.O.A.		X Charlestown							
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)										e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
Union Hospital											
3. NAME OF DECEASED (Type or print)		First Middle		Last		4. DATE OF DEATH		Month Day Year			
Willard		Brown		Frederick		11 18 19 59					
5. SEX M		6. COLOR OR RACE W		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>		8. DATE OF BIRTH Dec. 30, 1893		9. AGE (In years last birthday) 65 yrs.		10. IF UNDER 1 YEAR Months Days Hours Min. IF UNDER 24 HRS.	
WIDOWED <input type="checkbox"/>		DIVORCED <input type="checkbox"/>									
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?					
Clerk		Gravel Firm		Wilmington, Del.		U.S.A.					
13. FATHER'S NAME		14. MOTHER'S MAIDEN NAME									
William Frederick		Mary Ellen Walmsley									
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO.		17. INFORMANT		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]		Address			
						PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (b) (a), stating the underlying cause last.		INTERVAL BETWEEN ONSET AND DEATH			
						Acute Coronary Occlusion					
						PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)									
20c. TIME OF INJURY Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town)		(County)		(State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/>											
ACTUAL SIGNATURE R.C. Dodson		DATE SIGNED 11-18-59									
EXAMINER'S NAME (Type)		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>		DEPUTY MEDICAL EXAMINER <input type="checkbox"/>					
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 11-20-59		22c. NAME OF CEMETERY OR CREMATORIUM Riverview Cemetery		22d. LOCATION (City, town, or county) Wilmington, Newcastle Co., Del.		(State)			
23. FUNERAL DIRECTOR'S SIGNATURE Joseph R. Grant North East Md		ADDRESS		24a. REC'D BY REGISTRAR DATE NOV 23 '59		24b. REGISTRAR'S SIGNATURE Arthur S. Krause					

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial or removal.

87. **PROBLEMS** IN THE FIELD OF HUMAN RELATIONS

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

12482

CERTIFICATE OF DEATH

Reg. Dist. No.

12463
No. 6

- HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
- FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in by [REDACTED] funeral director, page 3 should be detached for use as the burial/transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/55

1. PLACE OF DEATH a. COUNTY Cecil MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE Md. b. COUNTY Cecil				
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rising Sun		c. LENGTH OF STAY IN lb Life		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rising Sun		d. STREET ADDRESS		
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
3. NAME OF DECEASED (Type or print) Anna		First Blanche	Middle Gillespie	Last Gillespie	4. DATE OF DEATH Nov. 19 1959	Month Nov.	Day 19	Year 1959
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 4 // 22 // 1880		9. AGE (In years lost birthday) 79 yrs.	10. IF UNDER 1 YEAR Months 0		11. IF UNDER 24 HRS. Days 0
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY Retired		11. BIRTHPLACE (State or foreign country) Cecil Co. Md.		12. CITIZEN OF WHAT COUNTRY? U.S.A.		
13. FATHER'S NAME William Albert Boyd				14. MOTHER'S MAIDEN NAME Emma Catherine MacDowell				
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO. None		17. INFORMANT Mrs. Nellie Weiser		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Myocardial Infarction DUE TO 420.1 Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause lost. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)						
20c. TIME OF INJURY Hour a. m. p. m.	Month 19	Doy 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) Rising Sun, Md.	(County) Colora	(State) Md.	
21. I certify that I attended the deceased from 9 , 19 59 , to 11/19 , 19 59 , that I last saw the deceased alive on 11/19 , 19 59 , and that death occurred at 11:30A M, from the causes and on the date stated above. ACTUAL SIGNATURE O Neil Taylor M.D. PHYSICIAN'S NAME (Type) Rising Sun, Md. 11/20/59								
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 11/22/1959	22c. NAME OF CEMETERY OR CREMATORIAL West Nottingham Cem.			22d. LOCATION (City, town, or county) Colora			
23. FUNERAL DIRECTOR'S SIGNATURE Yemone M. Muller				ADDRESS Rising Sun, Md.	24a. REC'D BY REGISTRAR DATE NOV 23 '59	24b. REGISTRAR'S SIGNATURE Orline S. Krause		

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending", in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

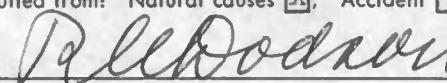
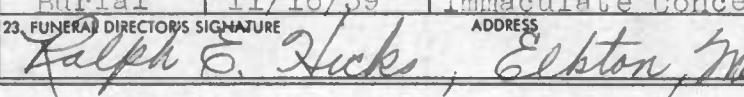
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial or removal.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

12464

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Cecil		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) b. STATE Maryland	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) North East River Beach		c. LENGTH OF STAY IN 1b Visiting	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Arundel Corp. property		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 249 Mackall Street	
3. NAME OF DECEASED (Type or print) Samuel		First Raymond	Middle Hague
Last		4. DATE OF DEATH November 12 1959	Month Day Year
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> b. DATE OF BIRTH WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> July 25, 1888	9. AGE (In years last birthday) 71 yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired		10b. KIND OF BUSINESS OR INDUSTRY Carpenter	11. BIRTHPLACE (State or foreign country) Cecilton, Maryland
13. FATHER'S NAME Samuel Edward Hague		14. MOTHER'S MAIDEN NAME Mary Harris	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. 216-07-1789	17. INFORMANT Mrs. S. Raymond Hague, Elkton, Md.
Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]			
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute Coronary Occlusion			
420.1 DUE TO			
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b)			
DUE TO			
(c)			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input checked="" type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Hour o. m. p. m.		Month, Day, Year 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) Elkton	(County) Maryland
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and find that death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/>			
ACTUAL SIGNATURE 		DATE SIGNED Nov. 13, 1959	
EXAMINER'S NAME (Type) R. C. Dodson, M. D.		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 11/16/59	22c. NAME OF CEMETERY OR CREMATORIAL Immaculate Conception
22d. LOCATION (City, town, or county) Elkton, Maryland		(State)	
23. FUNERAL DIRECTOR'S SIGNATURE 		ADDRESS Ralph S. Sticks, Elkton, Md.	24a. REC'D BY REGISTRAR DATE NOV 23 '59
24b. REGISTRAR'S SIGNATURE 			

TO HOSPITAL DIRECTOR: The low requires that the death certificate be executed within 24 hours after death. Page 4
TO ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Item 4 FilmG252 11-30-59 et

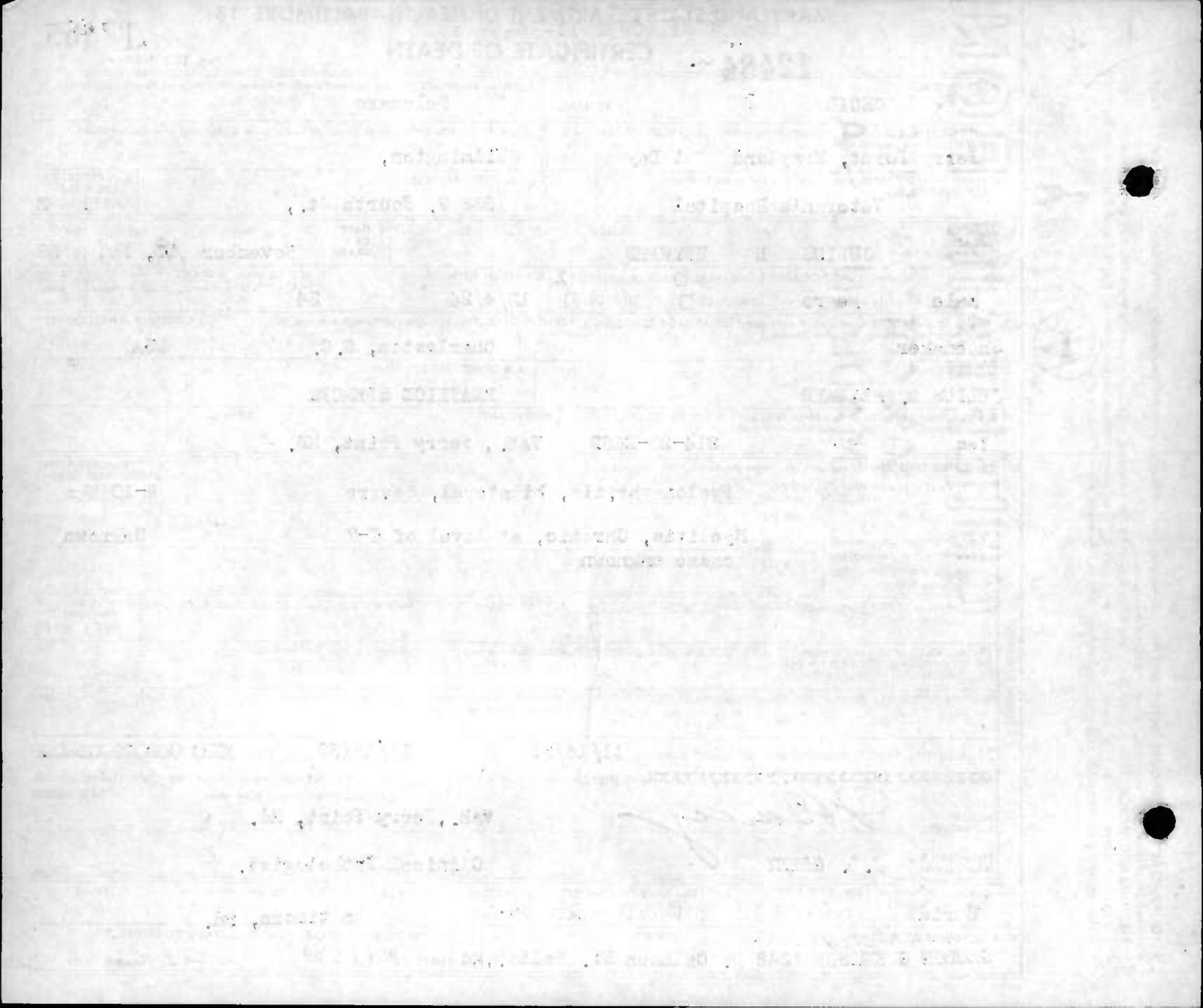
12465

CERTIFICATE OF DEATH

Reg. Dist. No.

12484

1. PLACE OF DEATH a. COUNTY CECIL		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Delaware b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Ferry Point, Maryland		c. LENGTH OF STAY IN 1b 1 Day	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Veteran's Hospital		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Wilmington, 46 X - 3	
d. STREET ADDRESS 1533 W. Fourth St.,		d. STREET ADDRESS e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) JULIUS N. HEYWARD		First JULIUS	Middle N
Last HEYWARD		4. DATE OF DEATH November 10, 18, 19 59	Month Day Year
5. SEX Male		6. COLOR OR RACE Negro	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>
		8. DATE OF BIRTH 12/4/24	
9. AGE (In years lost birthday) 34 yrs.		10. IF UNDER 1 YEAR Months 0 Days 0	11. IF UNDER 24 HRS Hours 0 Min. 0
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Shoemaker		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) Charleston, S.C.		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME JULIUS N. HEYWARD		14. MOTHER'S MAIDEN NAME BEATRICE SPENCER	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Yes		16. SOCIAL SECURITY NO. 214-20-2669	
17. INFORMANT VAH, Perry Point, Md.		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Pyelonephritis, bilateral, Severe 343 X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Myelitis, Chronic, at level of T-7 DUE TO cause unknown (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) Unknown			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. 19 p. m. _____		20d. INJURY OCCURRED While Not while at work <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 11/16/59 , 19, to 11/17/59 , 19, X that I saw the deceased give up the ghost, and that death occurred at _____ M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) VAH, Perry Point, Md. DATE SIGNED 11/17/59			
ACTUAL SIGNATURE <i>J. L. Garey</i>		M.D.	
PHYSICIAN'S NAME (Type) J. L. GAREY		Clinical Pathologist.	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 11-13-59	
22c. NAME OF CEMETERY OR CREMATORIAL Baltimore Crem		22d. LOCATION (City, town, or county) (State) Baltimore, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE <i>George G. Kelson</i>		ADDRESS 1348 N. Calhoun St. Baltimore, Md.	
24a. REC'D BY REGISTRAR DATE NOV 19 '59		24b. REGISTRAR'S SIGNATURE <i>James S. Thomas</i>	



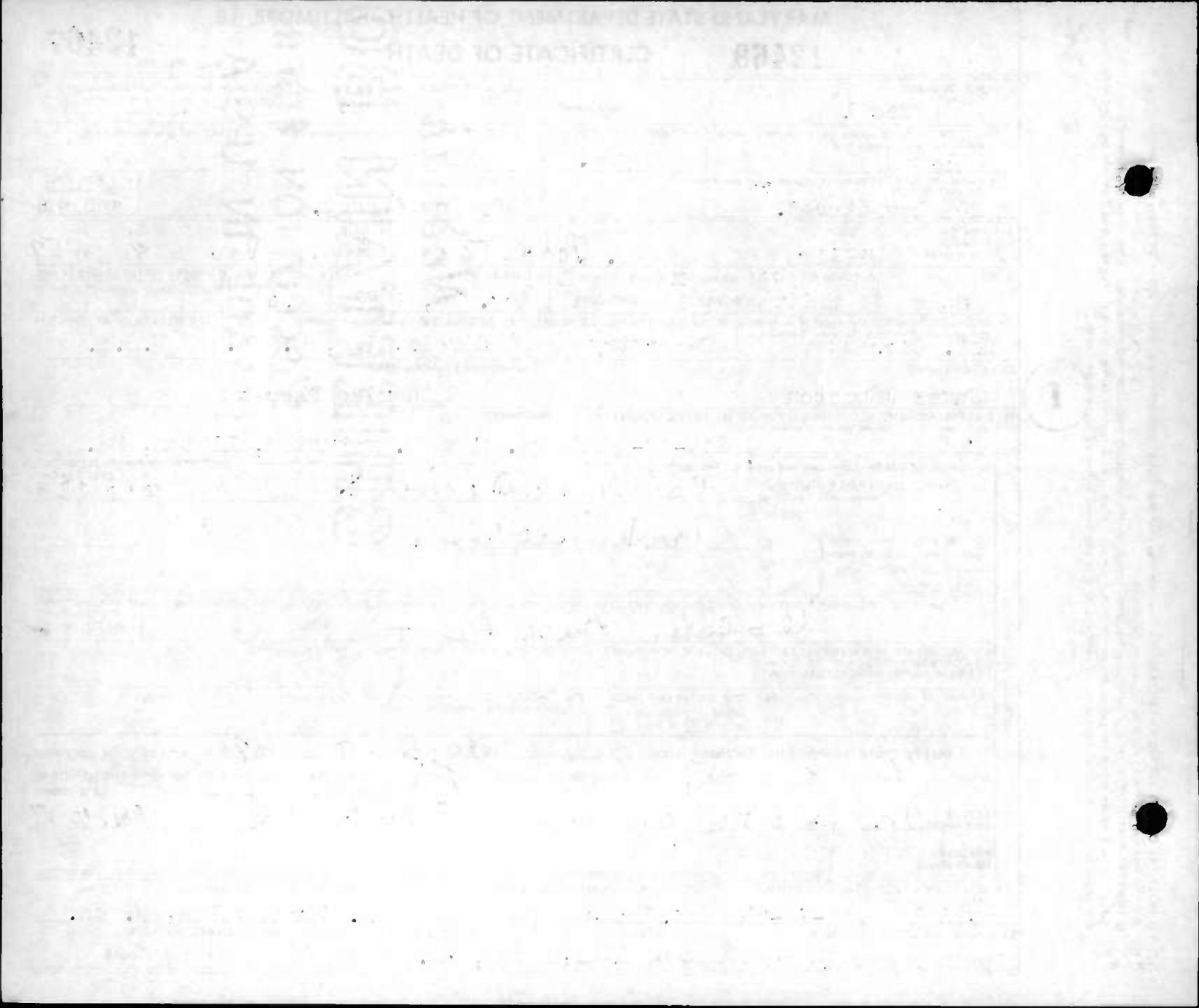
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4
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MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18										12466	Reg. Dist. No.		
12468 CERTIFICATE OF DEATH													
1. PLACE OF DEATH a. COUNTY Cecil					2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MARYLAND					b. COUNTY Maryland			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Elkton			c. LENGTH OF STAY IN 1b Lifetime			c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Elkton			d. STREET ADDRESS 156 W. Main				
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 156 W. Main					d. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>								
3. NAME OF DECEASED (Type or print) Charles Herman Jeffers					First	Middle	Last	4. DATE OF DEATH 11	Month	Day	Year		
5. SEX M.		6. COLOR OR RACE W.	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH July 28 1876			9. AGE (In years lost birthday) 83 yrs.		IF UNDER 1 YEAR Months Days		IF UNDER 24 HRS. Hours Min.		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Prop Restaurant					10b. KIND OF BUSINESS OR INDUSTRY Restaurant			11. BIRTHPLACE (State or foreign country) Maryland			12. CITIZEN OF WHAT COUNTRY? U.S.A.		
13. FATHER'S NAME John Herman Jeffers					14. MOTHER'S MAIDEN NAME Mary Jane Cantwell					Address Elkton, Md.			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)					16. SOCIAL SECURITY NO. 218-32-1316			INFORMANT John E. Jeffers		INTERVAL BETWEEN ONSET AND DEATH 1 week			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 334X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) CHRONIC STARVATION CEREBRAL VASCULAR SCEROSIS										INTERVAL BETWEEN ONSET AND DEATH 4 weeks 5 years			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)					20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20c. TIME OF INJURY Hour o. m. p. m.		Month 19	Day	Year	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)				
21. I certify that I attended the deceased from <u>8/20</u> , 19 <u>59</u> , to <u>11/6</u> , 19 <u>59</u> , that I last saw the deceased alive on <u>11/6</u> , 19 <u>59</u> , and that death occurred at <u>3:15 P.M.</u> from the causes and on the date stated above.										ADDRESS (Street, city or town, state) 154 W. Main Elkton, Md.			
ACTUAL SIGNATURE Peter Stavros		DATE SIGNED 11/6/59											
PHYSICIAN'S NAME (Type) PETER STAVRAKIS M.D.													
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 11/4/59		22c. NAME OF CEMETERY OR CREMATORIAL Elkton Cemetery			22d. LOCATION (City, town, or county) Elkton		(State) Md.				
23. FUNERAL DIRECTOR'S SIGNATURE Walter du Bois		ADDRESS Elkton, Md.		24a. REC'D BY REGISTRAR NOV 4 '59			24b. REGISTRAR'S SIGNATURE Arthur S. Trahan						

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4
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MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18										12467
CERTIFICATE OF DEATH										Reg. Dist. No.
1. PLACE OF DEATH					2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)					
a. COUNTY Cecil					a. STATE Maryland					
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Elkton					c. LENGTH OF STAY IN 1b 40 yrs.					
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 205 Bow Street.					c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Elkton					
e. STREET ADDRESS 205 Bow Street.					d. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
3. NAME OF DECEASED (Type or print)		First	Middle	Last	4. DATE OF DEATH		Month	Day	Year	
William				W. Johnston	Nov. 9 1959					
5. SEX		6. COLOR OR RACE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH	9. AGE (In years last birthday)		10. IF UNDER 1 YEAR		11. IF UNDER 24 HRS.	
Male		White	WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	Aug. 26, 1873	86 yrs.		Months	Days	Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Ret. Carpenter			10b. KIND OF BUSINESS OR INDUSTRY Carpentry			11. BIRTHPLACE (State or foreign country) Circleville, W. Va.			12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME James Johnston					14. MOTHER'S MAIDEN NAME Catherine Phares					
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No					16. SOCIAL SECURITY NO. 214-12-3627					INFORMANT Mrs. Emma B. Johnston, Elkton, Md.
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]					INTERVAL BETWEEN ONSET AND DEATH Oct 23 -					
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 331X					Cerebral accident					
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b)					Arteriosclerosis					
DUE TO (c)										
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) Diabetes mellitus -										19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)					20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Hour a. m. p. m.					20d. INJURY OCCURRED While at work <input type="checkbox"/> Nat while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
19										
21. I certify that I attended the deceased from _____, 1959, to Nov. 9, 1959, that I last saw the deceased alive on Nov. 8, 1959, and that death occurred on Nov. 9, 1959, M, from the causes and on the date stated above.										ADDRESS (Street, city or town, state) Elkton, Md.
ACTUAL SIGNATURE Oneford H. Spreeker, M.D.										DATE SIGNED Nov. 10, 1959.
PHYSICIAN'S NAME (Type)										
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 11-12-59		22c. NAME OF CEMETERY OR CREMATORIAL Calhoun			22d. LOCATION (City, town, or county) Nr. Circleville, W. Va.			
23. FUNERAL DIRECTOR'S SIGNATURE Pippin Funeral Home					ADDRESS Elkton, Md.					
					24a. REC'D BY REGISTRAR DATE NOV 13 '59			24b. REGISTRAR'S SIGNATURE Curtis & Trans		



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4
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MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

12485

CERTIFICATE OF DEATH

12468

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY CECIL COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MARYLAND	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Perry Point, Md.		c. LENGTH OF STAY IN lb 6Y-2M -2D	
d. NAME OF HOSPITAL (If not in hospital, give street address) Veterans Hospital		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print)	First WILBUR	Middle J.	Last LEPPER
4. DATE OF DEATH	Month November	Day 11	Year 1959
5. SEX MALE	6. COLOR OR RACE WHITE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>	8. DATE OF BIRTH 5/23/09
9. AGE (In years last birthday) 50 yrs.	10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laborer	11. BIRTHPLACE (State or foreign country) Baltimore, Maryland	12. CITIZEN OF WHAT COUNTRY? USA
13. FATHER'S NAME JACOB LEPPER	14. MOTHER'S MAIDEN NAME Mary McDonald	INFORMANT Address	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Yes	16. SOCIAL SECURITY NO. WWII	17. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 527.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last. (b) DUE TO (c)	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			18. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> INTERVAL BETWEEN ONSET AND DEATH 3 Days
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Hour o. m. p. m.	Month 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while of work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)
21. I certify that I attended the deceased from 9/9/53 , 19, to 11/11/59 , 19, that I last saw the deceased alive on 11/11/59 , 19, and that death occurred at 2 p.m. , from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED Perry Point, Md. 11/11/59			
ACTUAL SIGNATURE <i>Joseph H. Hooper</i>	M.D.		
PHYSICIAN'S NAME (Type) JOSEPH H. HOOPER, MD.	Perry Point, Md.		
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL	22b. DATE THEREOF 11/16/59	22c. NAME OF CEMETERY OR CREMATORIUM Baltimore National	22d. LOCATION (City, town, or county) (State) Baltimore, Md.
23. FUNERAL DIRECTOR'S SIGNATURE <i>Wm Cook-Blight Inc. 6009 Harford Rd.</i>	ADDRESS <i>6009 Harford Rd.</i>	24a. REC'D BY REGISTRAR DATE 11/11/59	24b. REGISTRAR'S SIGNATURE <i>Arthur & sons</i>

Digitized by srujanika@gmail.com

**MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH**

12469

Reg. Dist. No.

DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File Pages 1 and 2 with the registrar prior to burial, cremation, or removal.

<p>1. PLACE OF DEATH a. COUNTY Cecil</p> <p>b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Barksdale</p> <p>c. LENGTH OF STAY IN 1b Life</p> <p>d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)</p>				<p>2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission)</p> <p>a. STATE Md.</p> <p>b. COUNTY Cecil</p> <p>c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) X Barksdale, Elkton, R.D.</p> <p>d. STREET ADDRESS /</p>			
<p>3. NAME OF DECEASED (Type or print) Mary J. Mahoney</p>				<p>4. DATE OF DEATH 11 21 19 59</p>			
<p>5. SEX F</p>		<p>6. COLOR OR RACE W</p>		<p>7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/></p> <p>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/></p>		<p>8. DATE OF BIRTH 8-16-1916</p>	
<p>10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) House work</p>		<p>10b. KIND OF BUSINESS OR INDUSTRY</p>		<p>11. BIRTHPLACE (State or foreign country) Maryland</p>		<p>12. CITIZEN OF WHAT COUNTRY? U.S.A.</p>	
<p>13. FATHER'S NAME William Mahoney</p>				<p>14. MOTHER'S MAIDEN NAME Mary J. Lewis</p>			
<p>15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no</p>		<p>16. SOCIAL SECURITY NO.</p>		<p>17. INFORMANT William Mahoney, Elkton, R.D. Md.</p>		<p>Address</p>	
<p>18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]</p> <p>PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 32 Caliber pistol wound below left nipple</p> <p>976 X DUE TO Conditions, if any, which gave rise to immediate cause (b) through to the back.</p> <p>(c)</p> <p>DUE TO (d)</p>							
<p>PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e)</p> <p>20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.</p> <p>20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Shot herself with 32 caliber revolver</p>							
<p>20c. TIME OF INJURY Month, Day, Year 750 a.m. 11 21 19 59</p>		<p>20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/></p>		<p>20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Home</p>		<p>20f. (City or town) Elkton, R.D. Cecil</p>	
<p>21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/>, Inspection <input type="checkbox"/>, Inquiry <input type="checkbox"/>, and find that death resulted from: Natural causes <input type="checkbox"/>, Accident <input type="checkbox"/>, Suicide <input checked="" type="checkbox"/>, Homicide <input type="checkbox"/>, Undetermined cause <input type="checkbox"/>.</p> <p>Actual Signature Elkton, R.D. Cecil</p>							
<p>EXAMINER'S NAME (Type) R.C. Dodson</p>				<p>DATE SIGNED 11-22-59</p>			
<p>22a. BURIAL, CREMATION, REMOVAL (Specify) Burial</p>		<p>22b. DATE THEREOF 11-24-1959</p>		<p>22c. NAME OF CEMETERY OR CREMATORIAL North East Methodist</p>		<p>22d. LOCATION (City, town, or county) North East, Cecil Co., Md</p>	
<p>23. FUNERAL DIRECTOR'S SIGNATURE Joseph B. Grant</p>				<p>ADDRESS North East, Maryland</p>		<p>24a. REC'D BY REGISTRAR Arthur S. Hanna</p>	
<p>24b. REGISTRAR'S SIGNATURE Arthur S. Hanna</p>				<p>DATE NOV 24 '59</p>			

WISCONSIN STATE CARNIVAL-GATLINBURG
HIGHLIGHT EXHIBITION OF DEATH

1000

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MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

12470

CERTIFICATE OF DEATH

Reg. Dist. No.

12470

1. PLACE OF DEATH a. COUNTY Cecil		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland		b. COUNTY cecil			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Elkton		c. LENGTH OF STAY IN 1b 7 days		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) North East Rural					
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Union Hospital				d. STREET ADDRESS		e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) Irene		First	Middle	Last	4. DATE OF DEATH 11	Month 11	Day 20	Year 1959	
5. SEX Female		6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH March 4, 1881		9. AGE (In years lost birthday) 78 yrs.	10. IF UNDER 1 YEAR Months Days		11. IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? USA			
13. FATHER'S NAME John H. White				14. MOTHER'S MAIDEN NAME Katherine E. Birmingham					
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO. -		INFORMANT Barclay Moore Jr. North East, Maryland		Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 420.1		Cerebrovascular accident				INTERVAL BETWEEN ONSET AND DEATH 4 days			
Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last. (b)		DUE TO Acute coronary thrombosis				7 days			
		DUE TO (c) Arteriosclerotic cardiovascular disease				unknown			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Hour o. m. p. m.		Month 19	Day	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) 233 E. Main St.	(County) 11/20/59	(State) Md.	
21. I certify that I attended the deceased from		October 1, 1959, to		November 20, 1959, that I last saw the deceased alive on November 20, 1959, and that death occurred at 6:10 A.M. from the causes and on the date stated above.		ADDRESS (Street, city or town, state) 233 E. Main St.		DATE SIGNED 11/20/59	
ACTUAL SIGNATURE <i>S. Ralph Andrews, Jr.</i>		M.D.							
PHYSICIAN'S NAME (Type) S. Ralph Andrews, Jr., M.D.				Elkton, Maryland					
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 11-23-1959		22c. NAME OF CEMETERY OR CREMATORIUM North East Methodist		22d. LOCATION (City, town, or county) North East Cecil Co., Md		(State)	
23. FUNERAL DIRECTOR'S SIGNATURE <i>Joseph R. Grant</i>		ADDRESS North East, Maryland		24a. REC'D BY REGISTRAR NOV 24 '59		24b. REGISTRAR'S SIGNATURE <i>Arthur S. Hanna</i>			

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MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

12471

CERTIFICATE OF DEATH

Reg. Dist. No.

12471

1. PLACE OF DEATH a. COUNTY Cecil		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Md. b. COUNTY Cecil	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Elkton		c. LENGTH OF STAY IN 1b Life	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 112 Landing Lane		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Elkton	
3. NAME OF DECEASED (Type or print) JOHN THOMAS MOORE		d. STREET ADDRESS 112 Landing Lane	
4. DATE OF DEATH November		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
5. SEX Male		6. COLOR OR RACE White	
7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>		8. DATE OF BIRTH July 20, 1884	
9. AGE (In years last birthday) 75 yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Carpenter		10b. KIND OF BUSINESS OR INDUSTRY State Roads	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME James M. Moore		14. MOTHER'S MAIDEN NAME Annie Mc Neal	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. Mrs. John T. Moore	
17. INFORMANT Elkton, Md.		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: (IMMEDIATE CAUSE (a)) 422.1 Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause lost. (b) DUE TO Cerebrovascular accident -left hemiplegia Arteriosclerotic cardiovascular disease (c) DUE TO		INTERVAL BETWEEN ONSET AND DEATH 30 min.	
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.		20d. INJURY OCCURRED While Not while at work <input type="checkbox"/> at work <input checked="" type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>October</u> , 19 <u>57</u> , to <u>Nov. 7</u> , 19 <u>59</u> , that I last saw the deceased alive on <u>Nov. 7</u> , 19 <u>59</u> , and that death occurred at <u>12:35a</u> , M, from the causes and on the date stated above. ACTUAL SIGNATURE <u>S. Ralph Andrews, Jr.</u> PHYSICIAN'S NAME (Type) <u>S. Ralph Andrews, Jr., M.D.</u>		ADDRESS (Street, city or town, state) <u>233 E. Main Street</u> DATE SIGNED <u>Elkton, Maryland</u> <u>11/7/59</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>Nov. 10, 1959</u>	
22c. NAME OF CEMETERY OR CREMATORIAL <u>Elkton Cemetery</u>		22d. LOCATION (City, town, or county) <u>Elkton, Maryland</u> (State)	
23. FUNERAL DIRECTOR'S SIGNATURE <u>PIPPIN FUNERAL HOME</u>		24a. REC'D BY REGISTRAR ADDRESS <u>Donald M. Lee</u> Elkton, Md. DATE <u>NOV 12 '59</u>	
		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Evans</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death: Page 4
 may be retained by the hospital or attending physician
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, Page 3 should be detached for use as the burial-transit Permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4
 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

12487

CERTIFICATE OF DEATH

12472

Reg. Dist. No. 96

1. PLACE OF DEATH a. COUNTY Cecil		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE MARYLAND	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Perry Point		c. LENGTH OF STAY IN 1b 27 yrs. 10 mo. 5 days	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Veterans Administration Hospital		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print)	First CHARLES	Middle E.	Last MUMFORD
4. DATE OF DEATH	Month November	Day 1	Year 1959
S. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 8-19-94
9. AGE (In years last birthday) 65 yrs.	10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Mechanic	10b. KIND OF BUSINESS OR INDUSTRY Automobile	11. BIRTHPLACE (State or foreign country) Maryland
12. CITIZEN OF WHAT COUNTRY? USA	13. FATHER'S NAME William J. Mumford		
14. MOTHER'S MAIDEN NAME Emily Larimore	15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) Yes WW I		
16. SOCIAL SECURITY NO. unknown	INFORMANT Hospital Records, VAH, Perry Point, Md.	Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Bronchopneumonia, bilateral, unresolved 420.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last. (b) Arteriosclerotic heart disease DUE TO (c)			INTERVAL BETWEEN ONSET AND DEATH 4-5 days
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)
21. I certify that I attended the deceased from December 27, 1931 , to November 1, 1959 , and that death occurred at 7:20 P.M. from the causes and on the date stated above.			
ACTUAL SIGNATURE <i>J. L. Garey</i>		ADDRESS (Street, city or town, state) M.D. V.A. Hospital, Perry Point, Md. 11-3-59	
PHYSICIAN'S NAME (Type) J. L. GAREY		DATE SIGNED Clinical Pathologist	
22a. BURIAL, CREMATION, REMOVAL (Specify) 11/5/59	22b. DATE THEREOF 11/5/59	22c. NAME OF CEMETERY OR CREMATORIAL Baltimore National	22d. LOCATION (City, town, or county) Baltimore, Maryland (State)
23. FUNERAL DIRECTOR'S SIGNATURE <i>Papenfus & Son</i>	ADDRESS Havre de Grace, Md.	24a. REC'D BY REGISTRAR NOV 6 '59	24b. REGISTRAR'S SIGNATURE Arthur S. Kraus

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harmless

harmless

aggressive - highly territorial

territorial

shy at first - becomes more territorial as you go on

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territorial

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MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

12473

Reg. Dist. No.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.
 TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

1. PLACE OF DEATH a. COUNTY Cecil		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE Del.		b. COUNTY New Castle		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Port Deposit, R.F.D.		c. LENGTH OF STAY IN 1b 1 hour		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Newark		d. STREET ADDRESS 6 Prospect Ave.		
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Md. Assembly Inc.						e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
3. NAME OF DECEASED (Type or print)	First Joseph	Middle M	Last Murphy	4. DATE OF DEATH 11 9 1959	Month 11	Day 9	Year 1959	
5. SEX M	6. COLOR OR RACE W	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH Jan 18 1899	9. AGE (In years last birthday) 60 yrs.	IF UNDER 1 YEAR Months 0	IF UNDER 24 HRS. Days 0	Hours Min. 00	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Plant Manager		10b. KIND OF BUSINESS OR INDUSTRY Explosive		11. BIRTHPLACE (State or foreign country) Pa.		12. CITIZEN OF WHAT COUNTRY? U.S.A.		
13. FATHER'S NAME Andrew Murphy				14. MOTHER'S MAIDEN NAME Elizabeth McHale				
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. 203-03-6809		17. INFORMANT Mrs. Mary C. Murphy, 6 Prospect Ave., Newark		Address Del.		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute Coronary Occlusion DUE TO 420.1 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c)								
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) 20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>								
20c. TIME OF INJURY Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) Newark	(County) Del.	(State) Del.
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .								
ACTUAL SIGNATURE <i>R.C. Dodson</i>	M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input type="checkbox"/>							DATE SIGNED 11-9-59
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 11/12-59	22c. NAME OF CEMETERY OR CREMATORIAL St. Johns Cem.		22d. LOCATION (City, town, or county) Newark, Del.		(State)		
23. FUNERAL DIRECTOR'S SIGNATURE <i>R.T. Jones Newark, Del</i>		ADDRESS		24a. REC'D. BY REGISTRAR Aut 13 59	24b. REGISTRAR'S SIGNATURE <i>Curth & Farnam</i>	DATE		

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4
 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

12489

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

Reg. Dist. No. 96

12474

1. PLACE OF DEATH a. COUNTY Cecil		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE New Jersey					
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Perry Point		c. LENGTH OF STAY IN 1b 5 mo. 11 days					
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Veterans Administration Hospital		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
3. NAME OF DECEASED (Type or print) ALICE		First ELISE	Middle OSBORNE				
4. DATE OF DEATH November 19 1959		Last OSBORNE	Month November				
5. SEX Female		6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>				
8. B. DATE OF BIRTH 12-10-78		9. AGE (In years last birthday) 80 yrs.					
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Nursing		10b. KIND OF BUSINESS OR INDUSTRY Reg. Nurse					
11. BIRTHPLACE (State or foreign country) New York		12. CITIZEN OF WHAT COUNTRY? USA					
13. FATHER'S NAME Theodore B. Osborne		14. MOTHER'S MAIDEN NAME Lydia Underhill					
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Yes		16. SOCIAL SECURITY NO. Unknown					
17. INFORMANT Hospital Records, VAH, Perry Point, Md.		Address					
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]							
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Bronchopneumonia, bilateral, unresolved DUE TO 420.0 INTERVAL BETWEEN ONSET AND DEATH 10-12 days							
Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last. (b) Arteriosclerotic heart disease DUE TO							
(c) Arteriosclerosis, generalized, severe							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 1b.)			
20c. TIME OF INJURY Hour a. m. 19 p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Name, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
VA							
21. I certify that I attended the deceased from June 8 1959 to November 19 1959 . to take care of the deceased XXXXXXXXXXXXXXXXXXXX and that death occurred at 7:00 AM , from the causes and on the date stated above.				ADDRESS (Street, city or town, state) DATE SIGNED			
ACTUAL SIGNATURE <i>J. L. Garey</i>		22. BURIAL, CREMATION, REMOVAL (Specify) REMOVAL		22b. DATE THEREOF 11/23/59		22c. NAME OF CEMETERY OR CREMATORIAL Beverly National	
23. FUNERAL DIRECTOR'S SIGNATURE <i>Pennington & Son</i>		ADDRESS Havre de Grace, Md.		24a. REC'D BY REGISTRAR NOV 27 '59		24b. REGISTRAR'S SIGNATURE <i>John S. Kraus</i>	

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

12475

12472

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Cecil		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Elkton		c. LENGTH OF STAY IN 1b 42 yrs.	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Union Hospital		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 21 Elkton	
3. NAME OF DECEASED (Type or print) Charles F. Rhoades		d. STREET ADDRESS 129½ W. Main Street.	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH March 4, 1882
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Machinist		10b. KIND OF BUSINESS OR INDUSTRY Machinery	
11. BIRTHPLACE (State or foreign country) Marysville, Pa.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME George Washington Rhoades		14. MOTHER'S MAIDEN NAME Sarah Ann Glossar	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. No.	
17. INFORMANT Mr. Guy Rhoades, Elkton, Md.		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 331X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last. (b) DUE TO Scorbutic Arteriosclerosis. (c)			
INTERVAL BETWEEN ONSET AND DEATH Nov. 2 1959			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (o) Acute Laryngeal Revertia.			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Hour a. m. p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from Nov. 2, 1959, to Nov. 4, 1959, that I last saw the deceased alive on Nov. 7, 1959, and that death occurred at 8 p. m., from the causes and on the date stated above. ADDRESS (Street, city or town, state) M.D. Elkton, Md. DATE SIGNED ACTUAL SIGNATURE Physician's Name (Type)			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 11-10-59	
22c. NAME OF CEMETERY OR CREMATORIUM Charlestown		22d. LOCATION (City, town, or county) Charlestown (State) Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Pippin Funeral Home		24a. REC'D BY REGISTRAR DATE NOV 13 '59	
ADDRESS Donald J. Zee Elkton		24b. REGISTRAR'S SIGNATURE Cuthbert & Evans	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

12476

12473

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Cecil		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Md. b. COUNTY Cecil	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Elkton		c. LENGTH OF STAY IN 1b 4 Days	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Union Hospital		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Warwick Md.	
d. STREET ADDRESS		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print)	First Almedia	Middle H.	Last Smith
4. DATE OF DEATH	Month Nov.	Day 15th.	Year 19 59
5. SEX female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Aug. 20th 1883
9. AGE (In years from birthday) yrs. 76	10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) House Wife	11. BIRTHPLACE (State or foreign country) Md.	12. CITIZEN OF WHAT COUNTRY?
13. FATHER'S NAME John Holden		14. MOTHER'S MAIDEN NAME Adranna Bennet	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO.	
17. INFORMANT Holden Moore Aberdeen Md.		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Massive cerebro-vascular accident		INTERVAL BETWEEN ONSET AND DEATH 4 days	
33/X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last. (b) DUE TO (c)		years.	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) senility		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Hour o. g. p. m.	Month, Day, Year 19	20d. INJURY OCCURRED White <input type="checkbox"/> Nat while at work <input type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)
21. I certify that I attended the deceased from 12 Nov , 19 59 , to Nov. 15th , 19 59 , that I last saw the deceased alive on Nov. 15th , 19 59 , and that death occurred at 315 PM, from the causes and on the date stated above. ADDRESS (Street, city or town, state) Wallace Obenshain		DATE SIGNED 16 Nov 59	
ACTUAL SIGNATURE Wallace Obenshain		M.D. Cecilton Md.	
PHYSICIAN'S NAME (Type) Wallace Obenshain, M.D.			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 11/18/59	22c. NAME OF CEMETERY OR Crematory Warwick Cemetery	22d. LOCATION (City, town, or county) Warwick Md.
23. FUNERAL DIRECTOR'S SIGNATURE G. Gust Daniels Middlebury Del.		24a. ADDRESS 12473	24b. REC'D BY REGISTRAR DATE Nov 19 59
		24b. REGISTRAR'S SIGNATURE Caroline S. Kline	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death: Page 4
may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

12490

CERTIFICATE OF DEATH

12477

Reg. Dist. No.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY Cecil		b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Perryville		c. LENGTH OF STAY IN 1b Life		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Md		b. COUNTY Cecil	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Aikin Ave.		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Perryville		d. STREET ADDRESS Aikin Ave.		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print)	First William	Middle Lackland	Last Taylor	4. DATE OF DEATH Month NOV.	Day 26	Year 1959			
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Feb. 1, 1874	9. AGE (In years lost birthday) 85 yrs.	IF UNDER 1 YEAR Months 0	IF UNDER 24 HRS. Days 0	Hours 0	Min. 0	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) telegraph operator		10b. KIND OF BUSINESS OR INDUSTRY B & O, R R		11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? USA			
13. FATHER'S NAME William Taylor			14. MOTHER'S MAIDEN NAME Eleanora Jackson						
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) NO		16. SOCIAL SECURITY NO.		INFORMANT Morton Taylor, Perryville, Md.		Address			
<p>18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]</p> <p>PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Chronic Myocarditis - 422.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last. (b) ARTERIO - Sclerosis - DUE TO (c)</p> <p>PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)</p> <p>19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/></p>									
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> of work <input type="checkbox"/>		20e. PLACE OF INJURY (Name, farm, factory, street, office bldg., etc.) APRIL 17, 1959		20f. (City or town) Nov. 25, 1959		(County) Colo	(State) Rural
21. I certify that I attended the deceased from APRIL 17, 1959 to Nov. 25, 1959 , that I last saw the deceased alive on Nov. 25, 1959 , and that death occurred at 6:15 P.M. from the causes and on the date stated above.									
ACTUAL SIGNATURE <i>Eleanora Jackson</i>		ADDRESS (Street, city or town, state) Perryville, Md.							
PHYSICIAN'S NAME (Type) Clarence I. Benson, M.D.		DATE SIGNED 11-29-1959							
22a. BURIAL, CREMATION, ETC. (Specify) Burial		22b. DATE THEREOF 11-29-1959		22c. NAME OF CEMETERY OR CREMATORIAL West Nottingham, Cem.		22d. LOCATION (City, town, or county) Colo, Md.			(State) Rural
23. FUNERAL DIRECTOR'S SIGNATURE <i>Clarence Patterson, Jr.</i>		ADDRESS Perryville, Md.		24a. REC'D BY REGISTRAR DATE NOV 30 '59		24b. REGISTRAR'S SIGNATURE <i>Clarence S. Benson</i>			

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

12478

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Cecil		b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Elkton		c. LENGTH OF STAY IN lb Life		d. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) Middletown		
						a. STATE Del.		
						b. COUNTY New Castle		
						c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Middletown		
						d. STREET ADDRESS 228 W. Main		
						e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
3. NAME OF DECEASED (Type or print)		First H arry	Middle D.	Last Thompson	4. DATE OF DEATH 11 3 59	Month 11	Day 3	Year 59
5. SEX M		6. COLOR OR RACE W	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	B. DATE OF BIRTH 8-28-01	9. AGE (In years last birthday) 58 yrs.	IF UNDER 1 YEAR Months	IF UNDER 24 HRS. Days	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Trucker		10b. KIND OF BUSINESS OR INDUSTRY Truck king		11. BIRTHPLACE (State or foreign country) Del.		12. CITIZEN OF WHAT COUNTRY? U.S.A.		
13. FATHER'S NAME Silas Thompson		14. MOTHER'S MAIDEN NAME Agnus Grant						
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO. 222-07-3065		17. INFORMANT Mrs. Harry Thompson, 228 W. Main St. Middletown		Address Del.		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]						INTERVAL BETWEEN ONSET AND DEATH		
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute Coronary Occlusion</u>		DUE TO						
420.1		(b)						
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.		DUE TO (c)						
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)						
20c. TIME OF INJURY Hour a. m. p. m.		Month, Day, Year 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) Middletown	(County)	(State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .								
ACTUAL SIGNATURE <i>R. C. Dodson</i>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input type="checkbox"/>		DATE SIGNED 11-3-59				
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 11/7/59	22c. NAME OF CEMETERY OR CREMATORIAL Old Fellowship Cemetery	22d. LOCATION: (City, town, or county) Middletown	(State)			
23. FUNERAL DIRECTOR'S SIGNATURE <i>G. L. Daniels</i>		ADDRESS Middletown Del.	24a. REC'D BY REGISTRAR NOV 5 '59	24b. REGISTRAR'S SIGNATURE <i>Arthur S. Trahan</i>				

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

DEPARTMENT OF HEALTH - CALIFORNIA
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

100-1000

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4
 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

1 MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
 12491 CERTIFICATE OF DEATH 12479
 Reg. Dist. No. 96

1. PLACE OF DEATH o. COUNTY CECIL		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MARYLAND	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) PERRY POINT		c. LENGTH OF STAY IN 1b 3 yrs 5 mos 25 days	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Veterans Administration Hospital		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) BALTIMORE	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		3. NAME OF DECEASED (Type or print) CHARLES HENRY WALKER	
4. DATE OF DEATH November 4, 1959	Month November	Day 4	Year 1959
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH November 21, 1894
		WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	9. AGE (In years last birthday) 64 yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Unknown		10b. KIND OF BUSINESS OR INDUSTRY unknown	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME JAMES WALKER		14. MOTHER'S MAIDEN NAME ALICE TERRELL	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Yes	16. SOCIAL SECURITY NO. (If yes, give war or date of service) WW-I	INFORMANT Hospital Records, VA Hospital, Perry Point, Md.	Address
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 490X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last. (b) DUE TO (c)			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Hour o. m. p. m.	Month 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) VA	(County) VA	(State) VA	
21. I certify that I attended the deceased from May 10, 1956 to November 4, 1959 , and that death occurred at 10:30 AM , from the causes and on the date stated above.			
ACTUAL SIGNATURE <i>A. Bernardo</i>		ADDRESS (Street, city or town, state) M.D. V.A. Hospital, Perry Point, Md. DATE SIGNED 11-5-59	
PHYSICIAN'S NAME (Type) A. BERNARDO		Asst. Chief, Surgical Service	
22a. BURIAL, CREMATION, REMOVAL REMOVAL	22b. DATE THEREOF 11-9-59	22c. NAME OF CEMETERY OR CREMATORIAL Baltimore National	22d. LOCATION (City, town, or county) (State) Baltimore, Maryland
23. FUNERAL DIRECTOR'S SIGNATURE <i>Pennington</i>	ADDRESS Havre DeGrace, Md.	24a. REC'D BY REGISTRAR DATE NOV 10 '59	24b. REGISTRAR'S SIGNATURE <i>Albert S. Thomas</i>

1949-10-20 10:00 AM

1949-10-20 10:00 AM

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MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

12492

CERTIFICATE OF DEATH

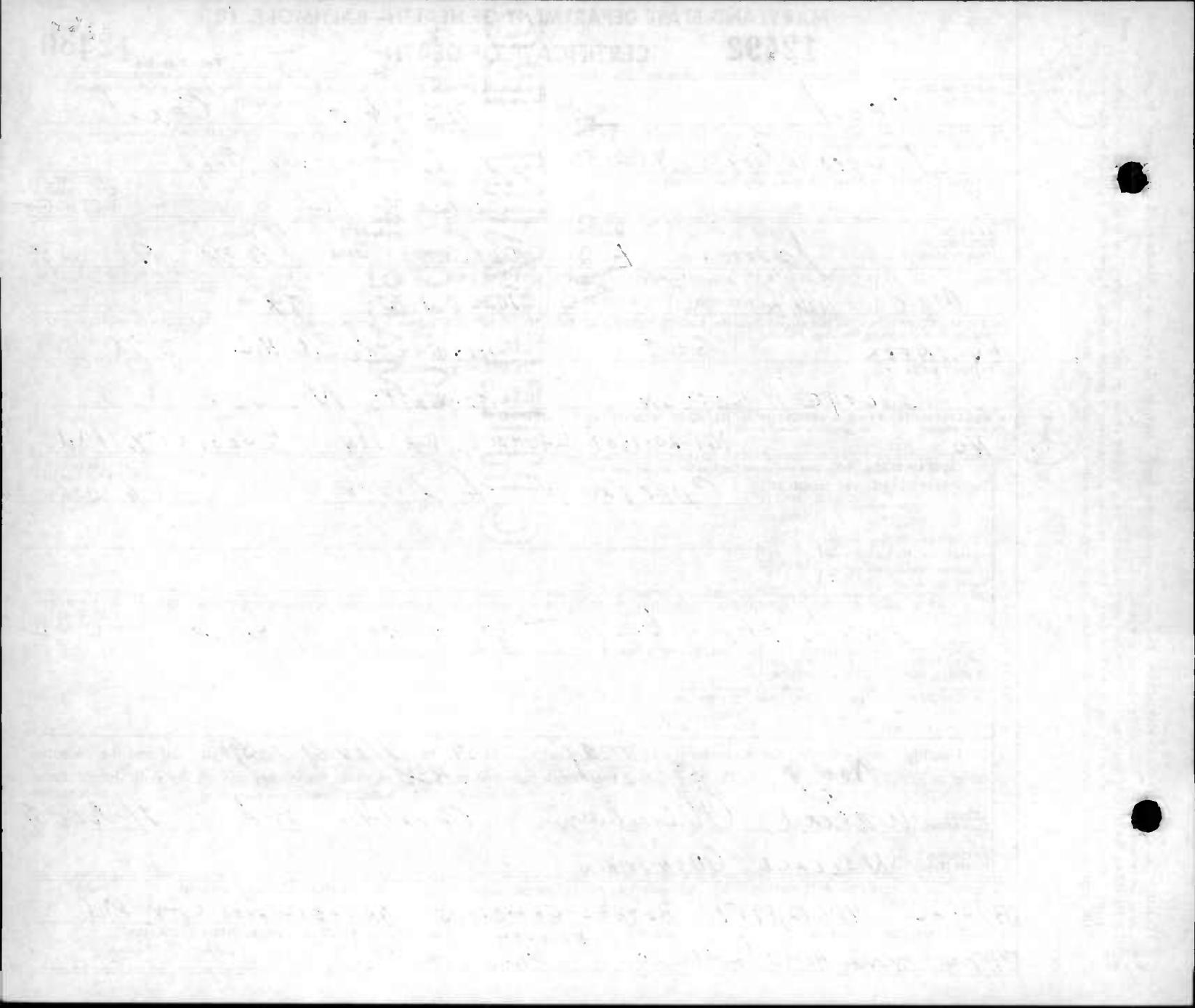
Reg. Dist. No.

12480

1. PLACE OF DEATH a. COUNTY <i>Cecil</i>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <i>Maryland</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Chesapeake City</i>		c. LENGTH OF STAY IN 1b <i>years.</i>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>X Chesapeake City</i>	
d. STREET ADDRESS <i>Summit Rd.</i>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print)	First <i>James</i>	Middle <i>E</i>	Last <i>Watson</i>
4. DATE OF DEATH	Month <i>Nov</i>	Day <i>9</i>	Year <i>1959</i>
5. SEX <i>Male</i>	6. COLOR OR RACE <i>White</i>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>June 8, 1880</i>
9. AGE (In years lost birthday) <i>79</i> yrs.	10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>ENGINEER</i>	11. KIND OF BUSINESS OR INDUSTRY <i>Govt.</i>	12. BIRTHPLACE (State or foreign country) <i>Chesapeake City, Md</i>
13. FATHER'S NAME <i>George R Watson</i>	14. MOTHER'S MATURE NAME <i>Henrietta Morgan</i>	15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <i>No</i>	
16. SOCIAL SECURITY NO. <i>169-20-1607</i>	INFORMANT <i>LAURA L. WATSON</i>	17. ADDRESS <i>CHESS. CITY, Md.</i>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>156.1</i> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last. (b) DUE TO (c)			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a) <i>Plethora thrombosis & pulmonary embolism.</i>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Hour o. m. p. m.	Month 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <i>May</i> , 19 <i>59</i> , to <i>Nov 9</i> , 19 <i>59</i> , that I last saw the deceased alive on <i>Nov 9</i> , 19 <i>59</i> , and that death occurred at <i>400</i> M, from the causes and on the date stated above.			
ACTUAL SIGNATURE <i>Wallace Openshain</i>	ADDRESS (Street, city or town, state) <i>Cecilton, Md.</i>		DATE SIGNED <i>11 Nov 59</i>
PHYSICIAN'S NAME (Type) <i>WALLACE OPENSHAIN</i>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>BURIAL</i>	22b. DATE THEREOF <i>Nov. 13, 1959</i>	22c. NAME OF CEMETERY OR CREMATORIUM <i>BETHEL CEMETERY</i>	22d. LOCATION (City, town, or county) (State) <i>MR. CHESAPEAKE CITY, Md.</i>
23. FUNERAL DIRECTOR'S SIGNATURE <i>PIPPIN FUNERAL HOME Donald Deo</i>	ADDRESS <i>ELSTON Md.</i>	24a. REC'D BY REGISTRAR DATE <i>NOV 18 '59</i>	24b. REGISTRAR'S SIGNATURE <i>Arthur S. Kline</i>

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4
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TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

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MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

12493

CERTIFICATE OF DEATH

Reg. Dist. No 96

12481

1. PLACE OF DEATH a. COUNTY Cecil		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Perry Point		c. LENGTH OF STAY IN 1b 7 days	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Veterans Administration Hospital		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Church Hill	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		d. STREET ADDRESS 17x-2	
3. NAME OF DECEASED (Type or print) GEORGE		First ELWOOD	Middle WESSEL
4. DATE OF DEATH November	Month 24	Day 19	Year 59
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>	8. DATE OF BIRTH 11-27-03
9. AGE (In years lost birthday) 55 yrs.	10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Storekeeper	10b. KIND OF BUSINESS OR INDUSTRY Grocery Store	11. BIRTHPLACE (State or foreign country) Maryland
12. CITIZEN OF WHAT COUNTRY? USA	13. FATHER'S NAME William H. Wessel		
14. MOTHER'S MAIDEN NAME Lena Story	15. WAS DECEASED EVER IN U. S. ARMED FORCES? Yes WW II 16. SOCIAL SECURITY NO. 215-14-3917 INFORMANT Hospital Records, VAH, Perry Point, Md. Address		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Neoplasm, left lobe of brain, (Temporal)</u> DUE TO 193.0 Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause lost. (b) <u>Type undetermined.</u> DUE TO (c)			
INTERVAL BETWEEN ONSET AND DEATH 4 Months			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (o) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. VA 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)
21. I certify that I attended the deceased from November 17, 1959, to November 24, 1959, and that death occurred at 8:15 AM, from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED			
ACTUAL SIGNATURE R. H. Twining		M.D. V.A. Hospital, Perry Point, Md. 11-25-59	
PHYSICIAN'S NAME (Type) R. H. TWINING		V.A. Medical Service.	
22a. BURIAL, CREMATION, REMOVAL (Specify) BIRIAL		22b. DATE THEREOF Nov. 27	22c. NAME OF CEMETERY OR CREMATORIUM Church Hill
22d. LOCATION (City, town, or county) Church Hill, Maryland		(State)	
23. FUNERAL DIRECTOR'S SIGNATURE Edgar Lane Funeral Home, Church Hill, Md.		24a. REC'D BY REGISTRAR DATE NOV 30 '59	24b. REGISTRAR'S SIGNATURE C. W. S. Kraus

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4
 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
 15M 9/58

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

12494

CERTIFICATE OF DEATH

Reg. Dist. No.

12482

1. PLACE OF DEATH a. COUNTY Cecil		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Pennsylvania	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Perry Point, Md.		c. LENGTH OF STAY IN 1b 32 yrs. 4 mos 9 days	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION VA Hospital, Perry Point, Md.		d. STREET ADDRESS Box 69	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print)	First JOSEPH W. WOTTCZAK	Middle Lost	4. DATE OF DEATH November 18 1959
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>	8. DATE OF BIRTH 1892
		WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	9. AGE (In years (or birthday) yrs.) 67
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Brewery Worker		10b. KIND OF BUSINESS OR INDUSTRY Brewery	
11. BIRTHPLACE (State or foreign country) Pennsylvania		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME John Wottczak		14. MOTHER'S MAIDEN NAME Unknown Nellie Micholskie	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Yes		16. SOCIAL SECURITY NO. Unknown	
		INFORMANT Hospital Records, VAH - Perry Point, Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Arteriosclerotic heart disease		INTERVAL BETWEEN ONSET AND DEATH Unknown	
420.0 Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last. (b) Arteriosclerosis, generalized, severe		Unknown	
DUE TO (c)			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Doy, Year Hour o. m. p. m. VA 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that deceased died on 11-18-59 at 5:00 AM , from the causes and on the date stated above. ADDRESS (Street, city or town, state) VAH., Perry Point, Maryland DATE SIGNED 11-18-59			
ACTUAL SIGNATURE <i>J. L. Garey</i>		PHYSICIAN'S NAME (Type) J. L. GAREY, M.D.	
CLINICAL PATHOLOGIST.			
22a. BURIAL, CREMATION, REINTERMENT CREMATION		22b. DATE THEREOF 11-19-59	
22c. NAME OF CEMETERY OR CREMATORIUM Youngwood Cemetery		22d. LOCATION (City, town, or county) (State) Youngwood, Pa.	
23. FUNERAL DIRECTOR'S SIGNATURE <i>Arthur S. Trahan</i>		ADDRESS Havre DeGrace	
		24a. REC'D BY REGISTRAR Arthur S. Trahan	
		24b. REGISTRAR'S SIGNATURE Arthur S. Trahan	

